BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Simon Joseph Lucio, M.D. Physician's & Surgeon's Certificate No. G 72884 Respondent.	Case No. 800-2019-062668

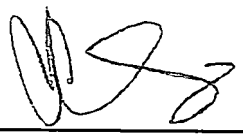
DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on March 23, 2023.

IT IS SO ORDERED: February 21, 2023.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SIMON JOSEPH LUCIO, M.D.** **3020 Children's Way, MC 5075** **San Diego, CA 92123** **Physician's and Surgeon's Certificate No. G 72884,** Respondent.	Case No. 800-2019-062668 OAH No. 2022050859 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Rosemary F. Luzon, Deputy Attorney General.

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2. Respondent Simon Joseph Lucio, M.D. (Respondent) is represented in this proceeding by attorney Elizabeth M. Brady, Esq., whose address is: Law Office of Elizabeth M. Brady, 8880 Rio San Diego Drive, Suite 800, San Diego, CA 92108-1642.

3. On or about November 5, 1991, the Board issued Physician's and Surgeon's Certificate No. G 72884 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-062668, and will expire on October 31, 2023, unless renewed.

JURISDICTION

4. On or about February 15, 2022, Accusation No. 800-2019-062668 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on or about February 15, 2022, at his address of record. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A true and correct copy of Accusation No. 800-2019-062668 is attached as Exhibit A and incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-062668. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws, having been fully advised of same by his attorney, Elizabeth M. Brady, Esq.

8. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations in Accusation No. 800-2019-062668, and Respondent hereby gives up his rights to contest those charges. Respondent further agrees that he has thereby subjected his Physician's and Surgeon's Certificate, No. G 72884 to disciplinary action.

10. Respondent agrees that if an accusation is ever filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2019-062668 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate No. G 72884 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

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14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Respondent Simon Joseph Lucio, M.D., Physician's and Surgeon's Certificate No. G 72884, shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a), subsection (4). This Public Reprimand is issued in connection with the allegations relating to Respondent's care and treatment of Patient A, which are set forth in Accusation No. 800-2019-062668, as follows:

1. PUBLIC REPRIMAND.

On or about January 6-7, 2016, you failed to provide adequate care and treatment to Patient A in your role as supervising attending physician, in violation of California Business and Professions Code section 2234, subdivision (b), as more fully described in Accusation No. 800-2019-062668, a true and copy of which is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge, specifically in the area of supervision of physician trainees, and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement in the amount of $21,922.88 (twenty-one thousand nine hundred twenty-two dollars and eighty-eight cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

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The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs.

5. FAILURE TO COMPLY. Any failure by Respondent to comply with the terms and conditions of the Disciplinary Order set forth above shall constitute unprofessional conduct and grounds for further disciplinary action.

6. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2019-062668 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Elizabeth M. Brady, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G 72884. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/16/2022 Simon Joseph Lucio M.D

SIMON JOSEPH LUCIO, M.D.
Respondent

I have read and fully discussed with Respondent Simon Joseph Lucio, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: Nov. 16, 2022

ELIZABETH M. BRADY, ESQ.
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 11/17/22

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

ROSEMARY F. LUZON
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2019-062668

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SIMON JOSEPH LUCIO, M.D.** **3020 Children's Way, MC 5075** **San Diego, CA 92123** **Physician's and Surgeon's Certificate No. G 72884,** Respondent.	Case No. 800-2019-062668 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about November 5, 1991, the Board issued Physician's and Surgeon's Certificate No. G 72884 to Simon Joseph Lucio, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2023, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . .

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
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> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
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> . . .

6. Section 2234 of the Code states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> . . .
>
> (b) Gross negligence.
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> . . .

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COST RECOVERY

7. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

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(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. G 72884 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient A,[1] as more particularly alleged hereinafter:

Respondent's Role and Responsibilities as Supervising Attending Physician

9. On or about the night of January 6, 2016, Respondent was working the overnight shift at the emergency department of Rady Children's Hospital in San Diego, California. He was assigned to be the supervising attending physician of Dr. S.C.

10. At the time, Dr. S.C. was a board-certified pediatrician who was undergoing training as a pediatric emergency medicine fellow. She was a third-year trainee nearing completion of the fellowship program.

11. According to Respondent, he works directly with his assigned trainees in the care and management of patients:

> [A] resident and/or fellow in training [ ] initially evaluates the patient, obtains a history of the present illness and past medical history, completes a physical examination, formulates a differential diagnosis, assessment and treatment plan. The trainees then present the patient and the aforementioned information to me at which point a discussion follows regarding the differential diagnoses, treatment options and plan of action to be initiated upon my approval. The trainee will then enter the agreed upon labs, medications, etc. into the electronic medical record. The ultimate treatment plan of action and patient disposition are determined only after discussion with the trainee and myself. . .

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[1] References to "Patient A" herein are used to protect patient privacy.

12. As the assigned supervising attending physician, the final decision as to the patient's care and management, including diagnoses, treatment options, plan of action, and disposition, lies with Respondent:

> My role as the attending physician included proctoring and examining all patients seen by the fellow and other trainees assigned to my shifts and discussing medical management and treatment options for those patients. . .The decision as to the ultimate treatment plan of action (including labs, medications, subspecialty consultations, etc.) and disposition occurs only after the proctoring attending has also evaluated/examined the patient and engaged in a thorough discussion with [the] trainee regarding their assessment and plan of action. Ultimately[,] the final decision as [to] the treatment plan lies with the proctoring attending on duty. . .

Patient A's Emergency Department Presentation

13. On or about January 6, 2016, at approximately 22:07, Patient A, who was a teenager, presented at the emergency department with her father after reportedly intentionally ingesting seven tablets of Midol and 10 tablets of iron at approximately 21:30.

14. Dr. S.C., as a trainee, was the initial emergency department provider to evaluate Patient A. Respondent, as the assigned supervising attending physician, worked directly with Dr. S.C. Given Dr. S.C.'s advanced level of training in her fellowship program, Respondent expected Dr. S.C. to function nearly independently. Respondent remained present in the emergency department during his shift and was available at all times to supervise and discuss the management and treatment plan for all patients evaluated by Dr. S.C.

15. At all times, Respondent was aware that in the case of acute iron ingestion, the serum iron level is critical in determining the level of iron toxicity and guiding medical management and, therefore, is an essential test to obtain. Respondent was also aware that a ferritin level has no utility in the evaluation or management of an iron overdose case.[2]

16. After Dr. S.C.'s initial examination of Patient A, she presented her findings to Respondent. They discussed the appropriate management for the patient's acute iron ingestion and agreed to obtain all of the labs and studies recommended by the poison center, including a 4-

[2] Ferritin is a protein that stores iron inside the cells. A ferritin test measures the level of ferritin in the body. Ferritin levels indicate the amount of stored iron, but they do not measure the iron levels outside of the cells. A serum iron test, in contrast, measures the amount of iron in the blood. After a suspected overdose of iron, a serum iron level is the most appropriate test to order to assess for acute toxicity.

hour post-ingestion serum iron level. Respondent and Dr. S.C. never discussed obtaining a ferritin level, nor did Respondent ever advise Dr. S.C. that a ferritin level be obtained given its lack of utility in the management of an acute iron ingestion. According to Respondent, he specifically discussed the absolute need of obtaining a serum iron level with Dr. S.C.

Respondent's Failures in His Care and Treatment of Patient A

17. Between approximately 22:42 on or about January 6, 2016, and 01:55 on or about January 7, 2016, Dr. S.C. placed the orders for the recommended labs and studies. At approximately 01:55, Dr. S.C. erroneously ordered a ferritin level test, not a serum iron level test.[3] Approximately six minutes later, at 02:01, Respondent electronically cosigned the erroneous ferritin order.

18. Respondent also electronically cosigned the other recommended orders, including a urine drug screen, acetaminophen level, salicylate level, comprehensive metabolic panel, and EKG. Similar to the ferritin order, Respondent electronically cosigned the orders within minutes of the orders being placed by Dr. S.C. Among these orders electronically cosigned by Respondent, there was no order for a serum iron level.

19. Respondent electronically cosigned the orders for Patient A, including the ferritin order, based on his assumption that Dr. S.C. had ordered the exact labs and studies they discussed. He scanned the orders, but did not notice that a ferritin level had been ordered instead of a serum iron level.

20. According to Respondent, Dr. S.C. verbally updated him on the results as they came in. Respondent also personally viewed the results of the urine drug screen, acetaminophen level, salicylate level, comprehensive metabolic panel, and EKG as they periodically posted in the results section of the patient's electronic medical record.

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[3] According to Dr. S.C., she intended to order a serum iron test for Patient A, not a ferritin test. However, when placing the order and typing the word "iron" into the electronic medical record system, the system automatically defaulted to "ferritin" and, as a result, a ferritin test was ordered instead of a serum iron test.

21. At this point, Respondent was aware that no serum iron level had been drawn or resulted yet. He also knew that the serum iron level "was the final lab pending that we needed in our medical decision process."

22. At approximately 02:57, the lab results for "Ferritin" were received. The ferritin level test showed a normal level of "8" ng/mL, with a reference range of 6-70 ng/mL. There were still no lab results for a serum iron level, because no serum iron level test had been ordered.

23. Subsequently, according to Respondent, Dr. S.C. verbally reported to him that the "iron level was normal" and below the threshold for toxicity. However, Respondent did not personally view the reported iron level in the results section of the patient's electronic medical record. Respondent presumed Dr. S.C.'s verbal report of a normal iron level to be correct and expected, given the reported quantity of iron ingested by Patient A, the other normal lab values, and the patient's clinical course.

24. Patient A was discharged home later that morning, soon after the last assessment at approximately 04:12. Prior to discharging the patient, Respondent conferred with Dr. S.C. They reviewed the lab results, the patient's ED clinical course, and met with the ED social worker. Respondent felt that the patient could be safely discharged home based on her clinical improvement and Dr. S.C.'s verbal report that the serum iron level was normal and below the toxicity threshold. Respondent made this discharge decision despite the absence of a serum iron level order and results, and despite the presence of an order and results for ferritin.

25. According to the Disposition section of the ED Provider Notes, Patient A was discharged in good condition. The Plan section then stated: "You were seen and assessed today in the Emergency Department following an[ ] ingestion of Midol and iron tablets. Your iron level here was normal." An update in the ED Course and Medical Decision Making section of the ED Provider Notes also stated: "Labs as per below, grossly WNL . . . Iron well below threshold."

26. At or around the time of discharge, Respondent completed and recorded an Attending Note in the ED Provider Notes. The Attending Note stated: "Patient seen and examined. History and physical examination reviewed with the resident. ***Key elements confirmed.*** Clinical presentation and management plan discussed. Agree with the above except as modified."

(Emphasis added.) Respondent made this attestation despite the absence of a serum iron level order and results, and despite the presence of an order and results for ferritin.

27. At approximately 05:18, Dr. S.C. completed the encounter note for Patient A and sent it to Respondent for his review and signature. According to Respondent, the ferritin results contained in the ED Provider Notes had not populated until this point. At approximately 05:30, Respondent signed the note. Notwithstanding the ferritin results now appearing in the ED Provider Notes and the continuing absence of an order and results for a serum iron level, Respondent signed the note and he did so without personally checking the lab results. According to Respondent, he had already discussed the lab results and clinical course at length with Dr. S.C., so he was "not [ ] compelled to later double-check those results that finally populated into the electronic medical record."

28. Following Patient A's discharge, on or about January 7, 2016, Patient A subsequently developed severe abdominal and chest pain, and returned to the emergency department. She was admitted later that day at approximately 15:04. Patient A was found to be in fulminant liver failure due to iron overdose and required an emergency liver transplant.

29. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to the following:

A. Respondent failed to take care in assuring that a serum iron level, which is the key lab test for a patient with a known or suspected excessive iron ingestion, was ordered, drawn, and resulted for Patient A.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 72884, issued to Respondent Simon Joseph Lucio, M.D.;

2. Revoking, suspending or denying approval of Respondent Simon Joseph Lucio, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Simon Joseph Lucio, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: FEB 15 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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